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IN THE

Supreme Court of the United States

LITTLE ROCK CARDIOLOGY CLINIC, P.A., *et al.*,
Petitioners,

v.

BAPTIST HEALTH, *et al.*,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

AMICUS CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PETITION FOR *CERTIORARI* OF LITTLE ROCK CARDIOLOGY CLINIC, *ET AL.*

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QUESTIONS PRESENTED

1. Whether as a matter of law patients with private health insurance and patients with Medicare and Medicaid benefits must be in a single antitrust market when government benefits are not interchangeable with private insurance from the perspective of hospitals, doctors, or patients?

2. Whether as a matter of law the relevant geographic market must be at least as large as the defendant's service area when the area of effective competition for the product is a smaller area in which all of the competitors are located?

3. Whether a court must grant a motion to dismiss an antitrust complaint by resolving market allegations and their reasonable inferences against the plaintiffs, when the complaint alleges specific injuries to competition from the alleged acts of monopolization?

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INTERESTS OF AMICUS *CURIAE* [1]

The American Medical Association (AMA) submits this brief as *amicus curiae* in support of the petition for *certiorari* of Little Rock Cardiology Clinic, P.A.;

[1] Pursuant to this Court's Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part. No such counsel and no party made a monetary contribution intended to fund the preparation or submission of this brief. Written consents from counsel for all parties have been filed with the Clerk of this Court.

Dr. Bruce E. Murphy and Bruce E. Murphy, M.D.P.A.; Dr. Scott L. Beau and Scott L. Beau, M.D.P.A.; Dr. David C. Bauman and David C. Bauman, M.D.P.A.; Dr. D. Andrew Henry and D. Andrew Henry, M.D.P.A.; Dr. David M. Mego and David M. Mego, M.D.P.A.; Dr. Paulo Ribeiro and Paulo Ribeiro, M.D.P.A.; Dr. William A. Rollefson and William A. Rollefson, M.D.P.A., the Petitioners in this cause.

The AMA, an Illinois not-for-profit corporation, is the largest professional association of physicians and medical students in the United States. Its physician members practice in all fields of medical specialization, in every state of the nation. The objects of the AMA are to promote the science and art of medicine and the betterment of public health.

In this case, Baptist Health, the dominant hospital servicing 67% of the privately insured patients in Little Rock and North Little Rock, conspired with Arkansas Blue Cross and Blue Shield, which covers 90% of the privately insured patients in Arkansas and the cities of Little Rock and North Little Rock. These entities conspired to prevent the successful operation of a new specialty hospital in Little Rock by retaliating against physicians who agreed to provide physician services at the new hospital. Rather than allow the development of the relevant facts, the Eighth Circuit affirmed the dismissal of the case, on a motion to dismiss, by crafting substantive antitrust rules that will make it virtually impossible for physicians and other health providers to challenge the exercise of market/monopsony power by health insurers and hospitals.

The AMA seeks to prevent dominant hospitals and health insurance companies from enhancing and

exercising their market/monopsony power in ways that will injure physicians and patients. It especially strives to prevent abuses of market power that would enable hospitals and health insurance companies to dictate the terms and conditions under which physicians care for their patients.

STATEMENT OF THE CASE

The AMA adopts the Petitioners' Statement of the Case and adds the following points:

1. The Alleged Anticompetitive Restraint

The Petitioners alleged that Baptist Health (Baptist) and Arkansas Blue Cross & Blue Shield (BC/BS) conspired to secure and enhance each other's market power. According to the complaint, Baptist would refuse to deal with insurance plans that competed against BC/BS, and BC/BS would refuse to deal with providers that competed against Baptist. Given Baptist's position as the dominant hospital in the Little Rock/North Little Rock area, insurance plans that could not include Baptist as an approved provider in their provider network were placed at a substantial competitive disadvantage vis-à-vis BC/BS. The alleged actions by Baptist, therefore, represent the use of market power to injure health insurance plans that competed against BC/BS.

When BC/BS refused to deal with a provider that competed against Baptist, BC/BS was exercising monopsony power—BC/BS' ability to exclude providers and thereby decrease the availability of health care services. The exercise of monopsony power injures both providers and patients. Providers are harmed by the artificial crippling of their ability to compete for patients. Patients are injured by a reduction in

the supply of physician services and reduced quality. *See*, "The Market Structure of The Health Insurance Industry," Congressional Research Service (November 17, 2009)("CRS Report"); Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thompson West 2007); Cory Capps, *Economic Analysis of Buyer Power in Health Plan Mergers,"* Journal of Competition, Law & Economics, (2009); Francis H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemporary Problems 195 (1988); Peter Hammer & William Sage, *Monopsony as an Agency and Regulatory Problem in Healthcare*, 71 Antitrust L.J. 697 (2003-04). *See, also*, Pet. App. 79a-80a, 120a-51a.

The Petitioners alleged facts showing that BC/BS had both market and monopsony power. *See*, Pet. App. 93a-120a. The Petitioners alleged that (a) BC/BS controlled approximately 90% of the patients covered by private health insurance in the Little Rock/North Little Rock area in 2006 (Pet. App. 91a-92a), and (b) entry had not taken place over many years, with large national insurers' abandoning the Little Rock/North Little Rock area. Pet. App. 120a. Further, the Petitioners alleged facts showing that BC/BS was able to increase premiums (Pet. App. 142a-45a, 150a-51a, 252a-53a) and that the level and quality of care in the Little Rock/North Little Rock area declined. Pet. App. 140a; 239a-50a.

Baptist played a critical role in keeping rivals of BC/BS out of the market, and BC/BS helped to maintain Baptist's dominant position in the Little Rock/North Little Rock area. A hospital or physician denied access to BC/BS would not have access to 90%

of the patients covered by private health insurance. This would make it more expensive for the disadvantaged provider to compete against Baptist, would adversely affect the provider's ability to operate at an efficient scale, and would force the provider to rely more heavily on lower paying government insurance programs.

Petitioners were victimized by the alleged conspiracy when they decided to establish and work at a new hospital (Arkansas Heart Hospital) that would compete against Baptist. BC/BS responded by excluding them from the provider network that served all of BC/BS' managed care plans. Pet. App. 127a-134a. As a result, the Petitioners' ability to compete for patients covered by BC/BS was effectively destroyed. When Petitioners still refused to abandon the Arkansas Heart Hospital, Baptist terminated the Petitioners' staff privileges at Baptist. Baptist's and BC/BS' actions crippled the Petitioners' ability to retain patients needing inpatient cardiology services who were covered by private health insurance. The conspiracy also injured patients by effectively denying them access to those physicians who were punished for competing against Baptist.

At the heart of the Petitioners' antitrust claim was Baptist's and BC/BS's possession and misuse of market/monopsony power in the Little Rock and North Little Rock area. Baptist had market power over inpatient hospital services, while BC/BS had market power with respect to private health insurance. Given the nature of the market power alleged by Petitioners, the Petitioners alleged a product market that included privately insured patients who require inpatient cardiology procedures. The Petitioners alleged that the relevant geographic market

was Little Rock and North Little Rock. Within these markets, Baptist and BC/BS had dominant positions. The Petitioners also alleged that entry into either Baptist's or BC/BS's markets was difficult and unlikely.

2. Proceedings Below

The district court dismissed the Petitioners' complaint on the ground that they had not properly alleged a product market or a geographic market. The Eighth Circuit affirmed the district court's decision. First, the Eighth Circuit held, antitrust Petitioners must allege a relevant market, because this is the only way a court can "determine the effect that an allegedly illegal act has on competition." *Little Rock Cardiology Clinic*, 591 F.3d 591, 596 (8th Cir. 2009). With respect to the market alleged by the Petitioners, the Eighth Circuit held that the Petitioners' proposed product market of privately insured patients was improper as a matter of law. According to the Eighth Circuit, the market must include government payers, because "[p]atients able to pay their medical bill, regardless of the method of payment, are reasonably interchangeable from the cardiologist's perspective-the correct perspective from which to analyze the issue in this case." *Id.*, at 597.

Second, the Eighth Circuit rejected, as a matter of law, the Petitioners' proposed geographic market, because the Petitioners had not alleged "that a low percentage of [Baptist's] patients enter its proposed geographic market." *Id.*, at 599.

REASONS FOR GRANTING THE PETITION

A. THE IMPORTANCE OF THIS CASE

1. The Eighth Circuit's Decision Undermines The Proper Enforcement and Development of Antitrust Law in Health Care Markets

The Eighth Circuit's decision threatens the proper development and enforcement of the antitrust laws in health care markets. Under the guise of ruling on market definition issues at the pleading stage, the Eighth Circuit has announced new substantive rules that will significantly hamper the proper application of the antitrust laws to health care markets. First, the Eighth Circuit has effectively held that private health insurers can never exercise monopsony power. Under the Eighth Circuit holding, the existence of such government paid health care programs as Medicare and Medicaid as a practical matter forecloses any claim that private health insurers can wield monopsony power. No federal court has ever announced such a rule, and the Eighth Circuit did not have any legal basis for it. This type of broad ruling, by even one federal appellate court, can negatively impact the development and enforcement of the antitrust laws throughout the nation.

Second, with respect to geographic market definition, the Eighth Circuit announced an incoherent pleading rule which is based on an empirical model that has been largely rejected and which has never been required by this Court. Specifically, the Eighth Circuit held that when defining a hospital's geographic market, a plaintiff cannot allege a market that leaves open the possibility of some unknown number of patients coming into the proposed geo-

graphic market. The rule is based on a model called the Elizinga-Hogarty test. *See* Kenneth G. Elzinga & Thomas F. Hogarty, "The Problem of Geographical Market Delineation in Antimerger Suits," *Antitrust Bulletin* 18, no. 45 (1973): 45–81; Kenneth L. Elzinga & Thomas F. Hogarty, "The Problem of Geographical Market Delineation Revisited: The Case of Coal," *Antitrust Bulletin* 23 (1978): 1–18. The Department of Justice (DOJ), the Federal Trade Commission (FTC) and many economists have concluded that the Elzinga-Hogarty test is not appropriately applied to health care provider markets.

Third, the Eighth Circuit also erroneously held that antitrust plaintiffs must allege "a relevant market in order to state a plausible antitrust claim." *Little Rock Cardiology Clinic,* 591 F.3d at 569. This holding conflicts with the holdings of other federal circuits. An antitrust plaintiff alleging a claim under Section One of the Sherman Act is obligated to prove that the defendants entered into an agreement that unreasonably restrains trade. *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447, 460-61 (1986). This Court has recognized, as have several courts of appeal, that a precisely defined antitrust market is not required when direct evidence of anticompetitive effects exists. *Id. See, also, Metro Industries, Inc. v. Sammi Corp.*, 82 F.3d 839 (9th Cir. 1996); *Toys "R" Us, Inc. v. F.T.C.*, 221 F.3d 928, 937 (7th Cir. 2000); *Todd v. Exxon Corp.*, 275 F.3d 191, 206-7 (2d Cir. 2001).

2. The Proper Application and Development Of The Antitrust Laws To Health Care Markets Is An Issue of Critical National Importance

Last month, the Patient Protection and Affordable Care Act, Pub. L. No. 111-48 (the PPACA) was enacted into law. This legislation followed the widespread recognition that access to affordable and high quality health care is a major problem in this country. The PPACA requires most U.S. citizens and legal residents to purchase health insurance, offers subsidies that will allow expanded access and creates exchanges through which small businesses can purchase health insurance policies. The Eighth Circuit's decision undermines the goals set forth in the PPACA by insulating from antitrust challenge highly concentrated health insurance markets in which market power and monopsony power predominate.[2]

B. THE EIGHTH CIRCUIT'S MARKET ANALYSIS IS FLAWED AND CONFLICTS WITH ESTABLISHED ANTITRUST AND PLEADING PRINCIPLES

1. Product Market Issue

The Eighth Circuit effectively held as a matter of law that private health insurers cannot exercise monopsony power when government paid health

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[2] In a recently published study, the AMA found that 99% of the health insurance markets it studied are highly concentrated under the concentration standards used by the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice, as set forth in their Horizontal Merger Guidelines. *AMA Competition Insurance: A Comprehensive Study of U.S. Markets* (2009 update). *See also* n.3 *infra*.

insurance exists. Since government paid health care is offered extensively in every part of the country, no antitrust plaintiff, including the FTC and the DOJ, could successfully allege monopsony power. The Eighth Circuit's decision will (a) impede the proper enforcement of the antitrust laws in a large and important segment of the economy, (b) distort and mangle the development of antitrust doctrine, and (c) undermine the federal government's efforts to control health care costs and ensure a high level of care.

(a) The Eighth Circuit's Product Market Analysis Conflicts With The Approach Adopted By This Court and Followed By Other Circuits

The Eighth Circuit based its rejection of the Petitioners' proposed product market on its belief that because physicians (cardiologists in this case) can obtain revenue from government paid health care (Medicare and Medicaid), a private health insurance plan could not exert monopsony power. The Eighth Circuit held that antitrust liability cannot turn on where physicians obtain their revenue. From this, the Eighth Circuit concluded that patients covered by private health insurance are interchangeable with patients covered by government paid insurance and, therefore, belong in the same product market.

i. The Eighth Circuit Erred When It Decided The Complex Issues Raised By The Monopsony and Market Power Aspects of This Case At The Pleading Stage

The principal error made by the Eighth Circuit was crafting a sweeping rule on the plausibility of monopsony power claims at the pleading stage. Evaluating

monopsony power is a complex and fact intensive analysis that is not amenable to cursory treatment. Further, principles developed for the exercise of market power (economic power used by a seller of goods against consumers) do not apply seamlessly to the exercise of monopsony power (economic power used by a purchaser of goods to distort the supply side of the market). While monopsony power and market power have comparable anticompetitive effects, they cause those anticompetitive effects differently. In particular, monopsony power reduces the supply coming into a market, which reduces output and leads to higher prices. *See*, CRS Report, at 26; Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thompson West 2007); Cory Capps., *Economic Analysis of Buyer Power in Health Plan Mergers,"* Journal of Competition, Law & Economics, (2009); Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*, 74 Antitrust L.J. 707 (2007); Francis H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemporary Problems 195 (1988); Peter Hammer & William Sage, *Monopsony as an Agency and Regulatory Problem in Healthcare*, 71 Antitrust L.J. 697 (2003-04); Mark V. Pauly, *Competition In Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988). *See, also*, Pet. App. 79a-80a, 120a-51a. *See, also*, 2 A Phillip E. Areeda & Hovenkamp, Antitrust Law, ¶575 at 363-64 (Aspen Publishers rev.ed 2002).

The Eighth Circuit erroneously applied sell-side market power principles to a monopsony power issue without the benefit of a developed record. Specifically, the Eighth Circuit treated physicians just like consumers and asked what options were available to

physicians. While this may make sense when analyzing the output side of the market, it does not necessarily make sense when analyzing the input, or supply, side of the market. A supplier's moving out of one line of business because of the exercise of monopsony power does not demonstrate that the market is functioning competitively. It shows that the monopsonist was able to reduce supply. Here, Petitioners alleged that patients in the relevant market seeking in-hospital cardiology procedures suffered harmful pricing and quality effects, because Baptist and BC/BS conspired to constrain the market inputs from Arkansas Heart Hospital and Petitioners. Pet. App. 79a-80a, 120a-153a.

ii. The Eighth Circuit's Analysis Conflicts With Antitrust Principles Developed By This Court and Other Circuits

This Court has held that a product market is defined as all products that are reasonably interchangeable with one another. *U.S. v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 380-81 (1956). While many products are "interchangeable" to some degree, antitrust law defines interchangeability in a manner that is consistent with the goals of protecting consumers and suppliers from the exercise of market/monopsony power. For example, while motorcycles and cars are interchangeable to some degree, this does not mean that cars and motorcycles constitute one market. These products have different characteristics, prices, functional uses and customer bases. The combination of these facts makes it plausible that the availability of motorcycles will not place a meaningful check on the ability of a car manufacturer to exercise market power.

The Eighth Circuit's error was to separate the issue of market power from the issue of product market definition. Putting aside the issue of entry, private health insurers can exercise market power over patients who need access to health insurance.[3] Access to Medicare and Medicaid is defined by statute. Patients excluded from Medicare and Medicaid can only obtain health insurance from private health insurance companies (or, sometimes, from their employers).

Patients covered by private health insurance, therefore, represent a distinct group of consumers over whom private health insurance firms can exercise market power. *National Collegiate Athletic Ass'n v. Board of Regents of University of Oklahoma*, 468 U.S. 85 (1984) (relevant market limited to premier college football games given consumer demand); *International Boxing Club of New York v. U.S.*, 358 U.S. 242 (1959)(market limited to championship prize fights). A private health insurer's ability to exercise monopsony power over physicians depends on what happens if physicians are excluded from, or leave, the private health insurance company's provider panel. If physicians cannot move their patients to the Medicare and Medicaid markets, excluding physicians from the private health plan will reduce the total level of supply in the market.

The Eighth Circuit's decision, therefore, is erroneous because it asked the wrong question. It asked

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[3] *See*, Complaint, *U.S. v. Aetna, Inc.*, No. 3-99 CV 398-H (N.D. Tex. June 21, 1999), *available at* http//www.usdoj.gov/atr/cases/f2500/2501.htm; Competitive Impact Statement, *U.S. v. UnitedHealth Group, Inc.*, No. 1:05CV02436 (U.S.D.C. Dec. 20, 2005), *available at* www.justice.gov/atr/cases/f215000/215034.htm.

whether physicians could shift their practices to Medicare and Medicaid patients (which, in general, they could not), instead of asking what BC/BS patients could do and whether BC/BS would care about the loss of a large number of physicians from its plan. Physicians' leaving BC/BS plans for Medicare and Medicaid cannot discipline BC/BS, if, as alleged in the complaint, BC/BS had market power on the output side (the sale of health insurance policies). *See*, Mark V. Pauly, *Competition In Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988). In that event, BC/BS would not face any competitive pain from a reduction in the number of physicians able to treat its patients. The patients of BCBS, however, would face a reduction in the level and quality of care.

The market proposed by the Petitioners correctly and plausibly identified a line of trade that was susceptible to the exercise of market/monopsony power. That was all the Petitioners were required to do at the pleading stage. The Petitioners' proposed product market, therefore, is a relevant antitrust product market because it identifies plausible anti-competitive effects and an unreasonable restraint of trade.

2. Geographic Market Analysis

With respect to Petitioners' claims against Baptist, the Eighth Circuit did not question that inpatient cardiology services was a plausible product market. It held, however, that Petitioners' limiting the relevant geographic market to the Little Rock/North Little Rock area was akin to "gerrymandering" a market. The Eighth Circuit's decision places an impossible and to a large extent incoherent pleading burden on antitrust plaintiffs.

(a) The Eighth Circuit's Geographic Market Holding

The Eighth Circuit recognized that the Petitioners alleged facts showing that the overwhelming majority of patients in the Little Rock/North Little Rock area used Baptist. It nevertheless held that Petitioners' alleged geographic market was implausible because they did not specifically allege that very few patients who lived outside these boundaries came into the Little Rock/North Little Rock area for treatment. The Eighth Circuit stated that because Petitioners alleged that some patients enter the Little Rock/North Little Rock area for hospital services, they could not limit the geographic market to the Little Rock/North Little Rock area:

> We hold only that where, as here, an antitrust plaintiff alleges that a firm competes in and draws its customers from a specified geographic area, it cannot then limit the relevant geographic market to a location smaller than that area based solely on the fact that consumers must travel to that smaller area to obtain the relevant service or product.

Little Rock Cardiology Clinic, 591 F.3d at 600-1.

(b) The Eighth Circuit's Decision Elevates A Largely Discredited Geographic Market Analysis Into a Black Letter Pleading Requirement In Health Care Antitrust Cases

This Court and other courts of appeal have repeatedly held that defining a geographic market is an intensively factual issue that looks to practical realities. *See, U.S. v. Philadelphia National Bank*, 374

U.S. 350 (1970); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990). When analyzing service markets, a critical reality is that consumers may have to travel to a specific location to receive the service. With respect to medical services, this Court and the courts of appeal have found that geographic markets are typically localized. *F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. at 460-61 (1986) (Court recognizes "reality that markets for dental services tend to be relatively localized"); *Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990). Most patients develop long standing relationships with their physicians (*see*, *California Dental Ass'n v. F.T.C.*, 526 U.S. 756 (1999)), and dislike traveling long distances for care.

Despite these complexities, the Eighth Circuit imposed on geographic market analysis a hard and fast pleading rule that ignores this Court's direction that a court must focus on the practical realities facing consumers. Specifically, the Eighth Circuit has adopted a rule that focuses on where the defendant gets its business instead of what consumers can realistically do in response to an attempt to exercise market power. *See*, *Philadelphia National Bank*, 375 U.S. at 357 (the "proper question to be asked . . . is not where the parties to the merger do business . . . but where the effect of the merger on competition will be direct and immediate"). If, for example, a hospital draws most of its patients from area A and the balance from area B, it does not necessarily follow that the hospital cannot exert market power over area A. The hospital's ability to exercise market power depends on the reactions of patients in areas A and B to price increases. For example, there exist many plausible situations in which the hospital could lose all of the patients in area B and still have the

ability to profitably exercise market power over the patients in area A. Whether the exercise of market power is profitable turns on the reactions of patients in area A.

The fact that some patients travel into a geographic area does not mean that patients within that area are equally willing to leave the area in response to the exercise of market power. For example, assume that area B has no hospitals and sits between areas A and C, each of which has comparable hospitals. The willingness of patients in area B to travel to areas A or C does not mean that patients from area A will travel to area C in response to the exercise of market power. Many factors will influence whether patients in area A are willing to travel to area C such as, for example, (a) the distance between areas A and C, (b) the frequency with which they have to see their physician, (c) the nature of their condition and the need to have quick access to a hospital, (d) the need for family members to also travel, (e) whether the health insurance available to patients in area A includes hospitals located in area C, and (f) access to information about hospitals in area C that is equivalent to the information available for hospitals in area A. This partial list of factors highlights the folly in the Eighth Circuit's trying to impose a bright line for geographic market analysis.

Moreover, the willingness of some patients to leave the Little Rock/North Little Rock area in response to the exercise of market power by Baptist does not necessarily mean that Baptist could not exert market power over the remaining patients. Baptist's ability to exert market power in the Little Rock/North Little Rock area depends on the reactions of all of its patients. Assume, for example, that a 10% price

increase would be unprofitable for Baptist, because it would lose practically all of the patients who live outside Little Rock/North Little Rock but come into the area for cardiology services and would also lose 10% of the patients who live within the Little Rock/North Little Rock area. This does not mean that a 20% price increase would also be unprofitable. If the sensitivity of patients to price increases is not linear, it is plausible that even a small price increase would drive away from Baptist all of the marginal consumers, but the non-marginal consumers would not leave even in the face of a much larger price increase.

The complex factual analysis required for geographic market definition is not amenable to determination at the pleading stage. Further, as the Eighth Circuit's decision shows, premature analysis of a geographic market typically will lead to poor substantive antitrust rules.

The Eighth Circuit apparently based its bright line rule on what is called the Elizinga-Hogarty test ("E-H Test"). The E-H Test was initially developed to identify geographic markets for homogeneous commodities like coal. Kenneth G. Elzinga & Thomas F. Hogarty, "The Problem of Geographical Market Delineation in Antimerger Suits," *Antitrust Bulletin* 18, no. 45 (1973): 45–81; Kenneth L. Elzinga & Thomas F. Hogarty, "The Problem of Geographical Market Delineation Revisited: The Case of Coal," *Antitrust Bulletin* 23 (1978): 1–18. The E-H Test identifies a geographic market if only small numbers of product leave the market and only small numbers of product enter the market. The concept is simple: the so called "little in from outside" and "little out

from inside" metrics reflect the cost of shipping commodities into and outside of a potential market.

While the E-H Test may have validity when applied to homogeneous commodity markets, its application to service markets involving highly differentiated services has been called into doubt. *See*, *In re Evanston Northwestern Healthcare Corp.*, No. 9315, (F.T.C April 28, 2008). During the 1990s, the FTC and several courts applied the E-H Test to hospital mergers. One of these mergers took place in northern California, and a court had determined that the merger would not raise anticompetitive concerns given the results of an E-H Test. The FTC analyzed, retrospectively, this merger and concluded that the substantial price increases by one of the merged hospitals indicated the exercise of market power. Steven Tenn, The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction (Federal Trade Commission working paper No. 293, 2008). The FTC's working paper was critical of the E-H Test:

> The Elzinga-Hogarty method for delineating the geographic market has been widely critiqued. Depending on the homogeneity of the hospitals involved and the level of travel costs, the Elzinga-Hogarty approach can either overstate or understate the willingness of consumers to substitute between hospitals . . . Capps *et al.* (2001) explain how the presence of a significant number of individuals with low travel costs may say little about the substitution patterns of those who face higher travel costs.

Id., at 5. The FTC's working paper concluded that:

> A central issue raised by the Sutter-Summit transaction was whether this patient flow indicated that travel costs were sufficiently low that the presence of other hospitals would prevent an anticompetitive price increase. Our results suggest they were an insufficient constraint.

Id., at 22-23.

The Eighth Circuit's elevating a dubious economic model into a substantive pleading requirement will seriously damage the enforcement and development of the antitrust laws.

C. ALLEGING A FORMAL PRODUCT AND GEOGRAPHIC MARKET IS NOT REQUIRED IN EVERY ANTITRUST CASE

The Petitioners alleged facts showing that BC/BS was able to increase premiums (Pet. App. 142a-45a, 150a-51a, 252a-53a), and that the level and quality of care in the Little Rock/North Little Rock area declined as a result of the conspiracy. Pet. App. 140a; 239a-50a. Despite direct evidence that competition was injured by Baptist's and BC/BS' conspiracy, the Eighth Circuit nonetheless required that Petitioners allege precise product and geographic markets. The Eighth Circuit's holding is incorrect as a matter of law and conflicts with antitrust principles announced by this Court and by other circuit courts of appeal.

The Second, Fourth, Seventh and Ninth Circuits have held that a detailed market definition process is unnecessary when direct evidence of anticompetitive effects exists. *See, Metro Industries, Inc. v. Sammi Corp.*, 82 F.3d 839 (9th Cir. 1996) ("If a plaintiff can show 'that the restraint has actually produced significant anticompetitive effects, such as a reduc-

tion in output,' 'a formal market analysis becomes unnecessary'"); *Toys "R" Us, Inc. v. F.T.C.*, 221 F.3d 928, 937 (7th Cir. 2000)(market power can be proven directly by demonstrating anticompetitive effects); *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991)("A detailed inquiry into a firm's market power is not essential when the — anticompetitive effects of its practices are obvious"); *Todd v. Exxon Corp.*, 275 F.3d 191, 206-7 (2d Cir. 2001)(a plaintiff "may avoid a 'detailed market analysis by offering proof of actual detrimental effects, such as reduction of output,'" *citing Capital Imaging Assoc's v. Mohawk Valley Med Assoc's*, 996 F.2d 537, 546 (2d Cir. 1993)). This Court has also held that a detailed market analysis is not necessary when direct evidence of anticompetitive harm exists. *See, F.T.C. v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986).[4]

CONCLUSION

The Eighth Circuit's decision in this case undermines the proper enforcement and development of the antitrust laws in an immensely large and important area of the economy: health care. Under the guise of pleading requirements, the Eighth Circuit has announced a series of substantive antitrust rules that will insulate harmful anticompetitive

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[4] That evidence of adverse competitive effects—not market definition—should be the focus of antitrust analysis is the general thrust of the Federal Trade Commission/Department of Justice proposed revisions to the Horizontal Merger Guidelines. According to the revised guidelines, market definition is neither an end itself nor a necessary starting point of merger analysis. US Dept. of Justice and Federal Trade Commission, Horizontal Merger Guidelines For Public Comment: Released on April 20, 2010, available at http://ftc.gov/os/2010/04/100420hmg.pdf.

practices. The importance of this case and the proper application of antitrust law to health care markets are underscored by the intense national debate over health care and the access and quality issues that underlie the *certiorari* petition. Questions of these importance merit resolution by this Court.

Accordingly, *amicus* prays that the petition for *certiorari* be granted.

Respectfully submitted,

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